

Hampshire Hospitals NHS Foundation Trust

Quality Report

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This report describes our judgement of the quality of care at this trust. It is based on a combination of what we found when we inspected, information from our 'Intelligent Monitoring' system, and information given to us from patients, the public and other organisations.

Ratings

Overall rating for this trust

Good



Are services at this trust safe?

Requires improvement



Are services at this trust effective?

Good



Are services at this trust caring?

Outstanding



Are services at this trust responsive?

Good



Are services at this trust well-led?

Good



Summary of findings

Letter from the Chief Inspector of Hospitals

Hampshire Hospitals NHS Foundation Trust was established in January 2012 as a result of the acquisition by Basingstoke & North Hampshire NHS Foundation Trust of Winchester & Eastleigh Healthcare Trust. The trust provides acute hospital services to approximately 600,000 patients in Basingstoke, Winchester, Andover and surrounding areas in Hampshire and West Berkshire.

The trust provides services from Andover War Memorial Hospital, Andover, Basingstoke and North Hampshire Hospital, Basingstoke and the Royal Hampshire County Hospital, Winchester. Outpatient and assessment services are provided from Alton, Bordon and Romsey Community hospitals, and the Velmore Centre in Eastleigh.

We undertook this inspection of Hampshire Hospitals NHS Foundation Trust as part of our comprehensive inspection programme. The trust was in band 6 based on our Intelligent Monitoring information system.

Trusts have been categorised into one of six summary bands, with Band 1 representing highest risk and Band 6 the lowest risk.

The inspection was announced and took place from 28 – 31 July 2015, with additional unannounced inspection visits on 13 and 14 August 2015. The inspection team included CQC senior managers, inspectors and analysts, doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers.

We inspected the following core services: urgent and emergency care, medical (including older people's) care, surgery, critical care, maternity and gynaecology, services for children and young people, end of life care, and outpatient and diagnostic services.

Overall, we rated this trust as 'good'. We rated it 'outstanding' for providing caring services and 'good' for effective, responsive and well-led service. We rated it as 'requires improvement' for safety.

Overall, we rated Andover War Memorial Hospital as 'requires improvement'. We rated Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital as 'good'.

Our key findings were as follows:

Is the trust well-led?

- The trust had a five year strategy that aimed to deliver high quality safe patient care through transforming services. There was a focus on emergency care to build a new critical treatment hospital and deliver local care in the general hospitals and integrated health and social care closer to home. There were operational plans to focus on priorities and immediate capacity issues. However, clinical services did not have strategic plans to develop in the short and medium term.
- Governance arrangements were well developed at trust, division, clinical service and ward level. The trust had a comprehensive integrated performance report to benchmark quality, operational and financial information. Clinical quality dashboards were available from board to ward to improve the quality of information, monitoring and reporting. Risks were appropriately managed and escalated to the board, although this varied in some areas.
- The trust had benefitted from the duration of the working relationships amongst its leadership team. Whilst challenge and reflective scrutiny had continued, the maturity of the organisation was such that there could be an unconscious way of working where structures were sometimes less significant. The leadership team had recognised the need for succession planning and an external assessment of its governance arrangements. The trust needed to improve its use of internal audit and clinical audit to review governance arrangements and provide assurance around risk and effectiveness.
- The leadership team showed commitment, enthusiasm and passion to develop and continuously improve services. The trust could demonstrate improvement against many of its quality priorities, although the level of avoidable harms, such as falls and pressure ulcers, remained the same.
- Staff at every level told us about the visibility and support of the chief executive. Staff were positive about working for the trust and the quality of care they provided. Many felt engaged with the trust priorities although some were concerned that they were not being listened to, and there was low morale in places based on staffing issues and management decisions.

Summary of findings

- The culture of the organisation was different across the three sites. The merger or harmonisation of hospitals (the trust preferred term) was acknowledged as work in progress but was seen as successful overall. There was a difference in confidence with the staff at Andover War Memorial Hospital, Royal Hampshire County Hospital (RHCH), Winchester and Basingstoke and North Hampshire Hospital (BNHH). There had also been variable progress with integrated working across the three sites. The trust was sighted on priority areas where patient safety, clinical effectiveness and operational risks might occur.
- There was a focus on improving patient experience and public engagement to develop services. The public were involved in nominating staff that demonstrated excellent practice through the WOW! Award scheme.
- The trust supported and encouraged staff to innovate and improve services.
- Cost improvement programmes were identified with clinical staff and were assessed for risks and monitored. Savings and productivity, however, were not being delivered as planned, mainly because of the cost of emergency admissions and the trust was in a managed financial deficit.
- The trust was in discussion with commissioners about plans for the new critical treatment hospital. Whilst the clinical model was understood there was concern about its affordability and sustainability. There was ongoing discussion and debate about the viability of different options and the risks involved. A decision had yet to be made.
- Staff followed infection control procedures and these were monitored, although this was not consistent and needed to improve in some areas.
- Medicines were appropriately managed and stored. However, fridge temperatures were not being regularly checked and monitored on some wards.
- Anticipatory medicines (medicines prescribed for the key symptoms in the dying phase ie pain, agitation, excessive respiratory secretions, nausea, vomiting and breathlessness) were prescribed appropriately.
- Equipment was checked and stored appropriately in most areas but this needed to improve on some wards, specifically for resuscitation equipment.
- Overall, staff had a good understanding of safeguarding adults and children.
- More staff needed to complete mandatory training.
- Patients' were assessed and monitored appropriately, for example, risk assessments were complete. However, the early warning score needed to be used consistently in surgery, and a tool was required for outpatients, for patients whose condition might deteriorate.
- The hospital had a higher than expected number of avoidable harms (pressure ulcers and falls) against their own targets. The trust was taking action to improve this, for example, care bundles were introduced to appropriately assess and treat patients,
- Critically ill children attending the emergency department were immediately referred to a paediatrician. There was a protocol for the transfer of critically ill children to a specialist care from the Southampton and Oxford retrieval team (SORT). The SORT team would provide specialist staff to support the child during the transfer.
- Medical staffing levels across the hospital were appropriate. National recommendations were followed, for example, for consultant presence in the emergency department, maternity, critical care and end of life care. There was consultant presence in the hospital over seven days with the exception of surgical services; there was 24 hour consultant cover arrangements across all services. Consultants in children and young people services were working additional sessions because of vacancies with junior doctors at middle grade level. This additional working was not sustainable in the long term.

Are services safe?

- Staff were encouraged to report incidents and there was learning from incidents to improve the safety of services locally and across the trust. However, information sharing needed to improve for some services at Andover War Memorial Hospital.
- In diagnostic imaging, staff were confident in reporting ionised radiation medical exposure (IR(ME)R) incidents and followed procedures to report incidents to the radiation protection team and the Care Quality Commission.
- Clinical areas, such as wards, theatres and clinics were visibly clean with appropriate cleaning schedules.

Summary of findings

- Nursing staffing levels were identified at trust level using an appropriate acuity tool. Planned staffing levels across all areas were higher than minimum recommendations. The hospital had a significant number of vacancies particularly in emergency medicine, medical and older people's care, surgery and children's and young people's services. Staffing levels were monitored and action was taken to fill vacancies from bank staff. Agency staff were not used. However, some medical and surgical wards did not always meet safe staffing levels. Nursing staff were coping by working longer hours, sharing staff or staff skills across shifts. Patients on these wards told us their needs were being met. The trust was implementing actions to mitigate for example, by developing skills in health care assistants and having ongoing recruitment campaigns, including employing staff from overseas. There was also innovation in developing new roles for staff, for example, majors practitioners in the emergency department and advanced critical care practitioners. However, we found in some areas, patient needs were not being met.
- Midwifery staffing levels did not meet national recommendations but staff worked flexibly and could provide one to one care for all women in labour.
- Radiographers at Royal Hampshire County Hospital worked alone overnight covering imaging services for the hospital and the emergency department. Radiographers reported a heavy workload and raised concerns about manual handling issues. Between 10.00pm and 8am, radiology was supported by an overnight outsourced radiologist service. Staff identified delays in the process to authorise request and provide advice on imaging which meant delays in the patient diagnosis.
- The new regulation, Duty of Candour, states that providers should be open and transparent with people who use services. It sets out specific requirements when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, giving truthful information and an apology. The trust monitored duty of candour through their online incident reporting

system. Overall, senior staff we spoke with were aware of duty of candour and talked about the importance of being open and transparent with patients and their families.

Are services effective?

- Staff were providing care and treatment to patients based on national and best practice guidelines. In some areas guidelines had been unified across the trust for consistency of care.
- Services were monitoring the standards of care and treatment. Patient outcomes were similar to or better than the England average. There were action plans to address where outcomes were worse when compared to the England average.
- Patients who had suffered a stroke would be taken to the Royal Hampshire County Hospital as this was the designated receiving unit for the specialist treatment of stroke in Hampshire. From October 2014 to December 2014, the hospital performed better than other trusts for meeting standards for specialist assessments, thrombolysis and provision of physiotherapy and occupational therapy and discharge processes. The hospital was similar to other trusts for care on the stroke unit, multi-disciplinary working and standards of discharge standards. The hospital performed significantly worse than other trusts in providing speech and language therapy and scanning.
- Patients with chest pain were taken to Basingstoke and North Hampshire Hospital as the designated centre for specialist treatment if possible. The hospital's performance was better than national average for patients with non-ST segment elevation myocardial infarction (a type of heart attack) who were seen by a cardiologist or a member of their team and treated on a cardiac ward or unit. The hospital performed below the national average for patients being referred for or had angiography.
- Patients received good pain relief across all services.
- Patients, particularly older patients, were supported to ensure their hydration and nutrition needs were met.
- Staff were supported to access training. Many staff had a high level of competency having undertaken specialty specific qualifications. There was evidence of regular staff appraisal although clinical supervision varied.

Summary of findings

- Staff worked effectively in multidisciplinary teams to centre care around patients. This included working with GPs, community services, and other hospitals. There were innovations in electronic records and the use of video conferencing in end of life care that enabled information to be shared about patient's clinical needs and preferences across the trust, and with community and GP services. However, paediatric inpatient physiotherapy was not sufficient for children and young people with Cystic Fibrosis at the weekends and this was of concern.
- Seven-day services were well developed, particularly for emergency patients. There was support from therapists: pharmacy and diagnostic services were less well developed.
- Staff had appropriate knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of Deprivation of Liberty Safeguards applications were correctly submitted to the Commission. However, the capacity assessments were not always documented or regularly reviewed in patient care records.
- 'Do Not Attempt Cardio Pulmonary Resuscitation' (DNACPR) forms were not always appropriately completed and did not include, for example, an assessment of the patient's mental capacity.
- Staff maintained patient's confidentiality, privacy and dignity in all areas, although the layout of bays in a few areas may have compromised patient's dignity at times.
- Patients and their relatives felt involved in their care and treatment, staff provided information and explanations in a way patients could understand. Patients felt that their views and considerations were listened to and acted upon.
- Records of conversations were detailed on patient records. This meant staff always knew what explanations had been provided and reduced the risk of confusing or conflicting information being given to relatives and patients.
- Patients and their families were supported by staff emotionally to reduce anxiety and concern. There was also support for carers, family and friends for example, from the chaplaincy, bereavement services for patients having end of life care, and counselling support where required.
- Data from the national surveys demonstrated that the hospital was similar to other trusts. Patients were very satisfied and would recommend the care they received.

Are services responsive?

Are services caring?

- Staff were caring and compassionate and treated patients with dignity and respect. There was a culture in the hospital of understanding and responding to patient's individual needs. This covered clinical and non-clinical staff such as porters and housekeeping staff who recognised the importance of their role in providing good quality care.
- Patient feedback was overwhelming positive across all services.
- We observed outstanding care for critical care patients, children and young people, patients having end of life care and patients attending outpatient and diagnostic imaging services. The staff had an ethos of providing person centred care and developed trusting relationship with patients and their families.
- Services were being planned to respond to increases in demand, staff capacity and patient needs. There was some innovation in models of care, for example, ambulatory care, acute assessment unit and early supported discharge. There was also joint work with partners, for example, to in-reach services for psychiatric assessment. Children's and young people services had reduced the number of beds to respond to staffing issues. Other areas were working on how to increase capacity.
- Bed occupancy in the trust was below the England average of 88% although this was higher on surgical wards. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- The trust was not meeting the national emergency access target for 95% of patients to be admitted,

Summary of findings

transferred or discharged within 4 hours. Ambulance handovers over 30 minutes were often delayed and patients often had to wait in the emergency department for admissions.

- During our inspection, there were very few medical patients on outlier wards (a ward that is not specialised in their care). Information from the trust demonstrated that these patients were regularly assessed.
- Patient bed moves happened frequently, including at night. Staff were ensuring that patients with lower dependency needs were moved and patients had not expressed concern about their moves.
- The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target and the 62-day referral-to-treatment target, although this had not been met in June 2015.
- The trust was achieving the 18-week referral-to-treatment time target for medical patients and some surgical patients. The target was not being achieved in orthopaedics and ophthalmology.
- The majority of patient who had cancelled surgical procedures for non-clinical reasons were re-booked for surgery within 28 days.
- The trust was meeting national waiting times for diagnostic imaging within six week, outpatient appointments within 18 weeks and cancer waiting times for urgent referral appointments within 2 weeks and diagnosis at one month and treatment within two months.
- The trust cancellation rate for appointments was 10%; the England average was 7%. Many of these clinic cancellations were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments
- Women were able to make choices about where they would like to deliver their babies. They had access to early pregnancy assessment and their preferred ante-natal clinics. Women in the early stages of labour had access to telephone support.
- Patient discharge was effectively supported. Patients were regularly reviewed and discharge coordinators worked to improve the discharge of patients with complex care needs. There was a discharge lounge for medical patients and early supportive discharge for

stroke patients. The trust had problems with increasing numbers of delayed transfers of care for community services, and was working with partners to improve this.

- Support for patients living with dementia was well developed, for example, there was specialist support, appropriate assessment, a sunflower symbol was used and staff had good awareness and training. There was good practice across the trust for supporting patients living with dementia and their carers.
- Support for people with a learning disability needed further development. Although there was support for carers, the hospital needed a flagging system or passport to identify and support patients and some staff identified the need for further training.
- The trust offers a number of one-stop clinics. The breast unit, for example, offers appointments to patients within two weeks following GP referral. The referrals were initially received into the central booking office and prioritised by consultants. Patients who attended the one stop clinics would see a clinician, have a biopsy taken and see a radiologist if required. If a cancer diagnosis was suspected, patients were told before leaving the clinic and an appointment given to discuss the outcome and treatment options. This unit provided a responsive service for patients who were anxious in relation to a potential cancer diagnosis.
- Patients having end of life care were identified by a butterfly symbol so that staff were aware of their needs and those of their family.
- There was a hospital at home service to deliver care to those patients identified as being in the last days or hours of life. The service was 24 hours and seven days a week. Multidisciplinary team working and innovations in electronic records and the use of video conferencing in end of life care also facilitated rapid assessment and access to equipment.
- Patients having end of life care had multi-disciplinary care focused on their physical, mental, emotional and social needs. Patients could have a rapid discharge to home arranged within 24 hours. However, there were delays to the rapid and fast track discharge processes (within 48 hours) and processes were being improved to meet national standards.
- All wards we visited provided care for patients in single sex accommodation bays, in line with Department of Health requirements.

Summary of findings

- Complaints were handled appropriately and there was evidence of improvements to services as a result. Some services, however, were not responding to complaints in a timely way.

Are services well-led?

- All services identified the plans to build a new Critical Treatment Hospital as the overall strategy for the trust and there were in-depth plans towards this across services. However, some services did not have specific strategies and plans in the short and medium term to respond to priorities. Some consultants identified concerns with the plans for the new hospital.
- Services had effective clinical governance arrangements to monitor quality, risk and performance. The outpatients department needed to further improve processes to manage risk and quality.
- Many staff told us overall they had good support from the local clinical leaders and staff engagement was good.
- Many staff identified the visibility and support of the chief executive of the trust.
- Joint working between Basingstoke and North Hampshire Hospital and Royal Hampshire County Hospital varied. This was important to improve standards, share good practice and develop efficient and effective services across the trust. This was well developed in the emergency department, critical care and end of life care. Some services at Andover War Memorial Hospital reported feeling 'disconnected' from the wider trust.
- The leadership for end of life care was outstanding. There were robust governance arrangements and an engaged staff culture all of which contributed to driving and improving the delivery of high quality person-centred care. This was an innovative service with a clear vision and supportive leadership and board structure.
- Patient engagement was mainly through survey feedback: however, there was some innovation, for example the use of social media in maternity, afternoon tea sessions with stroke patients and their families and 'through your eyes' a listening event for surgery.
- The trust had a WOW Award scheme to recognise outstanding service. Staff could be nominated by patients or their colleagues. Recognition through the WOW Awards had led to high levels of staff satisfaction throughout the service
- Ideas to innovative and improve services were encouraged. There was participation in research, quality improvement projects, and innovation in developing new roles for staff, such as the Majors practitioners, volunteers caring in dementia, advanced critical care practitioners.

We saw many areas of outstanding practice including:

- The trust is one of only two designated specialist treatment centres in the country for treatment of Pseudomyxoma. This is a very rare type of cancer that usually begins in the appendix, or in other parts of the bowel, the ovary or bladder. The hospital has treated more than 1000 such cases. The diverse multidisciplinary team has developed the skills to help patients through this extensive treatment, and share their knowledge on international courses and conferences.
- Through audit, surgeons working at the trust have changed practice world-wide, such as new techniques for the biopsy on operable tumours and the benefits of waiting six weeks after completing chemotherapy before performing liver resection.
- Every medical and care of elderly ward had an activity coordinator who planned and conducted different activities for patients after consulting them. The activities included a range of things such as arts and craft, music, dance, group lunches and movie time.
- GPs had access to electronic information held by the trust. This meant they were able to access electronic discharge summaries with up to date information available about care and treatment patients had received in hospital.
- A LEGO brick model, designed by a play leader, was used to prepare children for MRI scans. The model was successful in reducing children's fears and apprehension. The model had been adopted for use in other hospitals.
- The trust was developing innovative new roles for staff, for example, majors practitioners in the emergency department and advanced critical care practitioners.

Summary of findings

- Afternoon tea sessions were held for patients and their relatives in the stroke wards. This gave patients an opportunity to share their experiences, peer support and education. The session was also attended by a member of the stroke association team who delivered educational sessions related to care after stroke. Patients were also given information about support available in the community.
 - A nurse-led eight bedded day unit in the admissions and discharge lounge for patients who required certain medical interventions. Patients were referred to this service by the medical consultants and this service was helping to meet needs of patients who required medical intervention without prolonging their stay in the hospital. Patients were highly complimentary about this service.
 - When patients with complex needs on care of elderly wards were discharged to their new home, they were escorted by a member of nursing or therapy staff who spent up to an hour with patients in their new home. This had helped in offering elderly patients emotional support.
 - The early supported discharge team helped stroke patients for up to six weeks following their discharge from the hospital. The staff felt that this gave continuity of care and supported the patients in achieving their goals following the discharge.
 - Once a week the librarian attended the ward round in order to source relevant literature to assist the professional development of staff.
 - Critical care career pathways were developed to promote the development of the nursing team.
 - The critical care unit had Innovative grab sheets that detailed the essential equipment to care for each patient in the event the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.
 - The breast care unit is a fully integrated multi-disciplinary unit that was pioneering intraoperative radiotherapy for breast cancer at the Royal Hampshire County Hospital.
 - Kingfisher ward had activity coordinators who planned and conducted different activities for patients after consulting them. There was a range of activities offered, including arts and crafts, music, dance, group lunches and movie time.
 - Pregnant women were able to call Labour Line which was the first of its kind introduced in the country. This service involves midwives being based at the local ambulance operations centre. Women who called 999 could discuss their birth plan, make arrangements for their birth and ongoing care. The labour line midwives had information about the availability of midwives at each location and were able to discuss options with women and their partners. Labour Line midwives were able to prioritise ambulances to women in labour if they were considered an emergency. The continuity of care, and the rapid discharge of ambulances when they are really needed, have been two of the main benefits to women in labour. The Labour line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they were also awarded second place in the Midwifery Service of the Year Award.
 - The specialist palliative care team provided a comprehensive training programme for all staff involved in delivering end of life care.
 - The cardiac palliative care clinic identified and supported those patients with a non-cancer diagnosis who had been recognised as requiring end of life care.
 - The use of the butterfly initiative in end of life care promoted dignity and respect for the deceased and their relatives.
 - There was strong clinical leadership for the end of life service with an obvious commitment to improving and sustaining care delivery for those patients at the end of their lives.
 - All staff throughout the hospital were dedicated to providing compassionate end of life care.
 - The Countess of Brecknock Hospice contacted bereaved relatives following the death of a relative and sent a card on the anniversary of the patient's death.
 - The hospice at home service was pro-active in supporting patients in their own home.
 - All staff throughout the Countess of Brecknock Hospice were dedicated to providing compassionate end of life care.
- However, there were also areas of practice where the trust needs to make improvements.
- Importantly, the trust **must** ensure that:
- Patients in the ED are admitted, transferred or discharged within national target times of four hours.

Summary of findings

- There is an appropriate system to identifying patients with a learning disability.
 - Nurse staffing levels comply with safer staffing levels guidance.
 - The emergency resuscitation trolleys are appropriately checked and are sealed or tagged.
 - Medicines are appropriately managed and stored in surgery.
 - Controlled drugs in liquid form are managed and stored appropriately in all the medical wards
 - The early warning score is used consistently in surgery and a system is developed for use in outpatients.
 - Venous thrombo-embolism assessment occurs on admission for surgical patients.
 - Resuscitation equipment is appropriately checked and items are sealed and tagged.
 - Staffing in radiology complies with guidance so that staff do not have heavy workloads, and manual handling risks and staff have access to appropriate advice.
 - There is effective partnership working so that children and young people with mental health needs (CAMHS) have timely assessment and care reviews.
 - Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.
 - The outsourced diagnostic imaging service is appropriately monitored and managed to reduce delays.
 - There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.
 - MIU staff have access to up to date approved Patient Group Directions (PGDs)
 - MIU staff receive update mandatory training in basic life support and infection control
 - staff said
 - Safeguarding checks are consistently completed and recorded.
 - There is a clear hospital protocol for responding to a collapsed patient in an emergency at Andover War Memorial Hospital.
 - There is appropriate security on site for the protection of staff and patients in the MIU at Andover War Memorial Hospital.
 - Leadership concerns in the MIU are addressed and there is effective leadership from the nurse clinical lead and lead consultant to monitor and maintain clinical standards.
 - There is an effective system to identify, assess, monitor and improve the quality and safety of the MIU, the day care unit and outpatient services.
- The trust should
- Develop clinical service strategies that support planning, cross site working and the sustainability of services.
 - Continue plans for the harmonization of services across hospital sites to ensure consistency of service, staff confidence and opportunity for innovation across hospital sites.
 - Ensure governance arrangements are formally evaluated and action is taken around areas of risk and effectiveness.
 - Implement recommendations as planned from the board evaluation report including implementation of HR representation on the board and improving external relationships.
 - Ensure all staff feel appropriately engaged with plans for the new critical treatment hospital, and clinical models are agreed.

Professor Sir Mike Richards

Chief Inspector of Hospitals

Summary of findings

Background to Hampshire Hospitals NHS Foundation Trust

Hampshire Hospitals NHS Foundation Trust was established in January 2012 as a result of the acquisition by Basingstoke & North Hampshire NHS Foundation Trust of Winchester & Eastleigh Healthcare Trust. The trust provides acute hospital services to approximately 600,000 patients in Basingstoke, Winchester, Andover and surrounding areas in Hampshire and West Berkshire.

The trust provides services from Andover War Memorial Hospital, Andover, Basingstoke and North Hampshire Hospital, Basingstoke and the Royal Hampshire County Hospital, Winchester. Outpatient and assessment services are provided from Alton, Bordon and Romsey Community hospitals, and the Velmore Centre in Eastleigh.

Andover War Memorial Hospital opened in 1926. The hospital provides palliative medicine, inpatient rehabilitation, day hospital services, a minor injuries unit and a midwifery led birthing centre. A new outpatient unit opened in 2010. The site also houses the Countess of Brecknock Hospice, which provides six inpatient beds, day care, and a base for Macmillan Nurses.

The Royal Hampshire County Hospital in Winchester opened on its present site in 1868. The hospital has 457 beds and provides the full range of range of general hospital services including accident and emergency, general and specialist surgery, general medicine, intensive care, rehabilitation, chemotherapy, diagnostic services, out-patient clinics and paediatric care. The site also houses Florence Portal House (which provides maternity, neonatal, breast screening and some gynaecology services) and an education centre.

Basingstoke and North Hampshire Hospital (BNHH) opened in 1974 and is based just outside Basingstoke in

North Hampshire. The hospital has 529 beds and provides a full range of planned and emergency services. These include specialist services for rare or complex illnesses for patients across the UK, including liver cancer, colorectal cancer and pseudomyxoma peritonei (a rare lower abdominal cancer). A purpose built diagnosis and treatment centre (DTC) opened in 2005.

There are 5,124 staff employed by the hospital. The trust does not outsource for any contracted staff, and non-clinical staff are employed in all of the support functions such as portering, facilities management and catering provision.

We undertook this inspection of Hampshire Hospitals NHS Foundation Trust as part of our comprehensive inspection programme. The trust was in band 6 based on our Intelligent Monitoring information system.

Trusts have been categorised into one of six summary bands, with Band 1 representing the highest risk and Band 6 the lowest risk.

The inspection was announced and took place from 28 – 31 July 2015, with additional unannounced inspection visits on 13 and 14 August 2015. The inspection team included CQC senior managers, inspectors and analysts, doctors, nurses, allied healthcare professionals, 'experts by experience' and senior NHS managers.

We inspected the following core services: urgent and emergency care, medical (including older people's) care, surgery, critical care, maternity and gynaecology, services for children and young people, end of life care, and outpatient and diagnostic services.

Our inspection team

Our inspection team was led by:

Chair: Professor Bob Pearson, Medical Director, Central Manchester University Hospitals NHS Foundation Trust

Head of Hospital Inspections: Joyce Frederick, Care Quality Commission

The team of 46 included CQC managers, inspectors and analysts, and a variety of specialists including: Consultant gynaecologist and obstetrician; consultant surgeons; consultant anaesthetist; consultant physicians; consultant geriatricians; consultant radiologist; consultant in clinical oncologist; consultant

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paediatrician; specialist registrar doctors with experience in emergency medicine and critical care; consultant nurse in paediatric emergency department; midwife; gynaecology nurse; surgical nurses; theatre nurse; medical nurses; paediatric nurses, neonatal nurse

specialist, palliative care specialist nurse; critical care nurse; outpatient manager, board-level clinicians and managers, a governance lead; a safeguarding lead; a student nurse; and experts by experience.

How we carried out this inspection

To get to the heart of patients' experiences of care, we always ask the following five questions of every service and provider: Is it safe? Is it effective? Is it caring? Is it responsive to people's needs? Is it well-led?

We carried out an announced inspection visit to Andover War Memorial Hospital on 28 July 2015. We completed the trust inspection through unannounced and out-of-hours inspections to other services on 13 and 14 August 2015.

Before visiting, we reviewed a range of information we held and asked other organisations to share what they knew about the hospital. These included the clinical commissioning groups; Monitor; Health Education England; General Medical Council; Nursing and Midwifery Council; Royal College of Nursing; NHS Litigation Authority; and the local Healthwatch.

The CQC inspection model focuses on putting the service user at the heart of our work. We held two listening

events in Winchester and Basingstoke on Wednesday 22 July 2015 when people shared their views and experiences of the Hampshire Hospitals NHS Foundation Trust.

We conducted focus groups and spoke with a range of staff in the hospital, including nurses, matrons, junior doctors, consultants, governors, administrative and clerical staff, porters, maintenance, catering, domestic, allied healthcare professionals and pharmacists. We also interviewed service managers and the trust senior management team.

During our inspection we spoke with patients and staff from all areas of the hospital, including the wards and the outpatient department. We observed how people were being cared for and talked with carers and/or family members and reviewed personal care or treatment records of patients.

We would like to thank all staff, patients, carers and other stakeholders for sharing their balanced views and experiences of the quality of care and treatment at Hampshire Hospitals NHS Foundation Trust.

What people who use the trust's services say

- We held public listening events, on 22 July 2015. We spoke to 44 people. We met them in a community centre, the library and in the towns of Winchester and Basingstoke. Overall people were positive about the trust.

The positive comments were on the following:

- Comments were overwhelmingly positive about all services
- Local communities felt engaged with their local hospitals.
- Staff treated people as individuals.
- Very good care on dementia ward.

- The leadership of trust was seen to be key parameter of success and the excellent leadership, particularly from the chief executive was highlighted.
- The trust was planning for the future.

There were only a few negative comments:

- Sometimes people had to wait a long time for medicines before going home.
- Hospitals consultant prescriptions were sometimes ambiguous and clarification with the trust for dispensing in community pharmacy took a long time.
- Outpatient appointments were being cancelled and not re-booked.

Summary of findings

- Meal choices were not always very interesting.
- Discharge arrangements were not always clear, for example, post surgery and self-care information.
- The results of the NHS Friends and Family Test (FFT) - Trust scored above the England average for inpatient wards (March 2014 - January 2015) and the trust was in the top quarter of all trusts. The A&E scores showed that the trust was above the England average.
- The CQC adult inpatient survey (2014): The trust had performed similar to other trusts in the six areas of question on the hospital and ward, nurses, doctors, care and treatment, operations and procedures and leaving hospital.
- The CQC A&E survey (2014): (43 questions) The trust performed similar to other trusts for all questions. One question was in top 20% of trusts "Do you have confidence and trust in the doctors and nurses examining you and treating you?"
- The Cancer Patient Experience Survey (CPES) by the Department of Health 2013/14 is designed to monitor national progress on cancer care. Of 34 questions, the trust performed similar to other trusts overall. The trust was better than other trusts (in the bottom 20% of trusts) for one questions:

Hospital staff told patient they could get free prescriptions.

- The CQC Survey of Women's Experiences of Birth (2014) (17 questions) showed that the trust was performing about the same as other trusts on all questions on care, treatment and information during labour, birth and care after birth. The trust was in the top 20% of all trusts for one question: If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- The CQC Children's Surgery (2014). Trust scored similar to other trusts for all questions in different age groups. The trust was in the top 20% of trusts for one question 8 – 15 years. Do you feel that the people looking after you listened to you?
- Patient-led assessment of the care environment (PLACE) were self-assessments undertaken by teams of NHS and independent healthcare staff, and also by the public and patients. They focused on the environment. In 2014, the trust scored lower than the national average for cleanliness (94%, compared to 96% nationally), food (78%, compared to 90%), (privacy, dignity and well-being (82%, compared to 87%), and facilities (89%, compared to 92%).

Facts and data about this trust

Hampshire Hospitals NHS Foundation Trust:

Key facts and figures

The trust has three registered locations: The Basingstoke and North Hampshire Hospital (BNHH), Royal Hampshire County Hospital (RHCH) and Andover War Memorial Hospital.

1. Context:

- The trust has 1,024 beds - BNHH 529 beds; RHCH 457 beds; 38 beds Andover
- The local population is around 600,000, from Basingstoke, Winchester, Andover and surrounding areas in Hampshire and West Berkshire.
- The number of staff is around 5,124 .
- The board has 0% Black and ethnic minority member's representation of executive directors and 0% Black

and ethnic minority member's representation of non-executive directors; it has 50% female representation of executive directors and 33.3% female representation of non-executive directors.

- Deprivation: The three districts in which the trusts three hospitals are located are all in the first (ie least deprived) quintile in the English Indices of Deprivation 2010. Three other districts that the trust serves (East Hampshire, Hart and Eastleigh) are also in the first quintile (which comprises 66 districts in total).
- Life expectancy for both men and women was rated worse than the England average.
- The Trust's income was £344.3m in 2014/15
- The Trust's deficit in 2014/15 was (-) £4.3 m

2. Activity:

- Inpatient admissions: 115,011 (2014/15).

Summary of findings

- Outpatient attendances: 547,719 (2014/15) of which 23% were first attendances and 50% were follow up
- A&E attendances: 116, 283 (/2014 /15).
- Births: 3,073 (2014/15).
- Deaths: 1,433 (2014 /15).

3. Bed occupancy:

- General and acute:

Q1 2014/2015: 72.6%; Q2 2014/2015: 81.7%; Q3 2014/2015: 81.7%

This was lower than both the England average of 88% and the 85% level at which it is generally accepted that bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.

- Maternity was at 33.3% bed occupancy (April 2014 to December 2014) lower than the England average of 57.9%.
- Adult critical care was approx. 95% – above the England average of 87.6% (May 13 – Nov 14).

4. Intelligent Monitoring:

- The priority banding for inspection for this trust was 6, and their percentage risk score was 1.56%. (1 = highest risk; 6 = lowest risk)
- In the latest Intelligent Monitoring report (May 2015), this trust had four risks and no elevated risks. The risks identified were as follows:
- SSNAP Domain 2: overall team-centred rating score for key stroke unit indicator (Effective domain);
- Monitor – Continuity of service rating (Well-led domain);
- Composite of PLACE indicators (Cross-cutting).
- PLACE score for food.

5. Safe:

- 'Never events' in past year: 0 (2013/14).
- Serious incidents: 91 (2014/15)
- National Reporting and Learning System (February 2014 – January 2015): 6,544 events reported

England average

Deaths

0.3%

0.1%

Severe harm

0.6%

0.4%

Moderate harm

6.8%

4.0%

Low harm

29.6%

21.8%

No harm

62.7%

73.7%

- There were 74 cases of C Diff in this trust between April 2013 and March 2015 (average of 37 per year), and five cases of MRSA (2.5 per year).
- Data from the Patient Safety Thermometer showed that there were 42 falls, 521 pressure ulcers, and 188 cases of Catheter Urinary tract infections (March 2014 - March 2015).

Infection control (April 2013- March 2015)

- 74 cases of Clostridium difficile (average 37 per year) – no evidence of risk.
- Five cases of MRSA (2.5 per year) – no evidence of risk.

Waiting times

- A&E – Time to initial assessment: below England average and 15 minute standard (2014/15)
- A&E - Time to treatment: below England average and 60 minute standard (2014/15)

6. Effective:

- All mortality indicators for the trust are in line with other non-specialist trusts.

7. Caring:

- CQC Inpatient Survey (10 areas): similar to other trusts.
- Friends and Family Test inpatient: Significantly above the England Average (March 2014 – February 2015).

Summary of findings

- Friends and Family Test A&E: above the England Average (March 2014 – December 2014); Similar to the England average (September 2014, January 2014 to February 2015)
- Cancer Patient Experience Survey (34 questions): similar to other trusts for 33 questions; and highest scoring 20% for one question (2012/13 - 2013/14)
- Patient-Led Assessments of the Care Environment - below England Average: cleanliness, food, privacy, dignity and wellbeing and facilities.

8. Responsive:

- Between April 2014 and March 2015, this trust received 606 complaints. Average number of working days to close a complaint: 36 days.
- A&E four-hour standard – not met; below the England average and 95% target (April 2013 to December 2014).
- For the incomplete pathway, the referral to treatment pathway (92% of patients on the waiting list for less than 18 weeks). Overall performance 93.2% BNHH and 90.3% RHCH - March 2015.
- 96.7% of cancer patients were seen by a specialist within two weeks of an urgent GP referral (2014/15 Q4), which is above the operational standard of 93 %.
- The proportion of cancer patients waiting less than 31 days from diagnosis to first definitive treatment was 98.9% (2014/15 Q4, standard of 96%). 87.5% of cancer patients waited less than 62 days from urgent GP referral to first definitive treatment, which is above the standard of 85% (2014/15 Q4).

- Delayed transfers of care: 38.8% of those patients with a delayed transfer of care were awaiting Nursing Home Placement or Availability: that was above the England average of 12.4%.

9. Well- Led:


- NHS Staff Survey (2014): This trust performed in the top 20% of trusts for three key findings, and in the bottom 20% of trusts for two key findings. For the remaining 24 key findings analysed, the trust had a similar performance to other trusts. The response rate in this trust was 45% (higher than the median rate across all trusts of 43%).
- Staff Sickness rate was 3.71% - below the England average (February 2015)
- Use of bank and agency staff – below the England average.
- General Medical Council National Training Scheme Survey (2015): The trust was within expectations for all areas of the National Training Scheme Survey.

10. CQC Inspection History:

- There have been eight inspections at the Trust since 2011.
- 13 outcomes were inspected, and the hospital was compliant with 12 of these. The non-compliant Outcome 9 (Medicines management) was in November 2013 (Basingstoke) and 4 (care and welfare) and 13 (Staffing) Dementia themed review (January 2014), Winchester. The trust had compliance actions to improve.

Summary of findings

Our judgements about each of our five key questions

	Rating
<p>Are services at this trust safe?</p> <p>By safe, we mean that people are protected from abuse and avoidable harm.</p> <p>Overall we rated the safety of the services at the trust as ‘requires improvement’. For specific information, please refer to the individual reports for Andover War Memorial Hospital, Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital.</p> <p>The trust participated in the NHS sign up to safety campaign to reduced avoidable harm. The overarching guidance was to Listen, Learn and Act: Listen to patient, carers and staff, learn from what to say when things go wrong and take action to improve patients’ safety. The five key pledges covered were 1. To reduce avoidable harms by 50%, such as pressure ulcers and falls; 2. To learn from patient experience and incidents, for example, using listening events and simulation sessions in theatre and critical care; 3. Be honest, for example, through the duty of Candour and public information such as nurse staffing levels; 4. Collaborate with partners on safety, for example to prevent discharge delays or involve patients in research choices; and 5. Support staff, for example through human factors training, continuous improvement and recognition of achievement.</p> <p>The trust patient safety indicators did not demonstrate any evidence of risk. There had not been any Never events (a serious, largely preventable patient safety incident which should not occur if the available preventative measures had been implemented) in the last 12 months. The trust’s infection rates for methicillin-resistant staphylococcus aureus (MRSA) and Clostridium difficile were low when compared with trusts of similar size and complexity. The trust was similar to other trust for reporting incidents to the National Reporting and Learning System (NRLS) on time. However, the incidence of avoidable harms such as pressure ulcers and falls had not reduced and had increased on some wards. Staff reported that prevention measures were not always possible to take when there were concerns about staffing levels on some wards.</p> <p>We identified areas that required improvements in medicines management, particularly the review of fridge temperatures and use of patient group directions and equipment checks, the checking of equipment, particularly resuscitation equipment and the impact of staffing levels on some wards and in radiology overnight at RHCH.</p> <p>Assessing responding to risks</p>	<p>Requires improvement</p> 

Summary of findings

- Patients' were assessed and monitored appropriately, for example, risk assessments were complete.
- Patients who arrived by ambulance in the emergency departments were assessed and monitored appropriately. The trust had implemented procedures to ensure this happened even with emergency departments might become overcrowded.
- The Five Steps to Safer Surgery (ED) was being used. Audit demonstrated high compliance but identified a few areas where surgeon participation needed to improve.
- Critically ill children attending the emergency department were immediately referred to a paediatrician. There was a protocol for the transfer of critically ill children to a specialist care from the Southampton and Oxford retrieval team (SORT). The SORT team would provide specialist staff to support the child during the transfer.
- The early warning score needed to be used consistently in surgery, and a tool was required for outpatients, for patients whose condition might deteriorate.
- There was a critical care outreach team at BNHH but not at RHCH. AT RHCH, outreach services were provided by the critical care medical staff. The hospital was monitoring and acting on any risks to patient safety but recognised the need to develop a critical care outreach team.

Duty of Candour

- The trust Duty of Candour (Being Open) Policy was developed in January 2014 and advised staff to be open and transparent with services users and saying sorry when things go wrong. The policy had been updated in January 2015, to take account of the Duty of Candour regulation which came into effect in the NHS on 27 November 2014. The policy introduced procedures and guidance for the trust to meet the requirements of the Duty of Candour. The trust serious event review group monitors the implementation of the policy.
- The Duty of Candour requires healthcare providers to disclose safety incidents that result in moderate or severe harm, or death. Any reportable or suspected patient safety incident falling within these categories must be investigated and reported to the patient, and any other 'relevant person', within 10 days. Organisations have a duty to provide patients and their families with information and support when a reportable incident has, or may have occurred.
- Most services had a culture of openness and transparency even if the 'duty of candour' was not part of the safety vocabulary of the trust. Information was available on the trust intranet to

Summary of findings

support staff to understand and implement the requirement of being open when things go wrong. Senior staff could describe their responsibilities around duty of candour and the trust supported them to be open and transparent about the need to identify mistakes, accept responsibility and apologise. There was evidence that the Duty of Candour was being implemented.

Safeguarding

- Trust Adult Safeguarding Steering Committee is responsible for the implementation of the policy for the protection of vulnerable adults within the Trust and setting strategic direction for the continual monitoring of that policy. The trust safeguarding lead was the Chief Nurse and there was a head of safeguarding. Operational managers and senior clinical staff had a key role to ensure adult safeguarding procedures were appropriately implemented in divisions and clinical areas. The policy had been updated to include new national recommendations, for example, the Themes and lessons learnt from NHS investigations into matters relating to Jimmy Savile, Prevent Strategy (prevention of terrorism) and recommendations to record and act on female genital mutilation (FGM). For example, there was procedures for celebrities and dignitaries visiting the trust and all volunteers had been DBS checked.
- The trust was working with partners to ensure an area wide approach to adult safeguarding issues, particularly as the majority were issues about pressure ulcers from community care services, which were recognised on admission to the hospital or disclosed to staff during the patients stay. The majority of trust internal safeguarding alerts, identified by staff or outside agencies, were issues of physical abuse, neglect or omissions of care, such as pressure ulcers, falls, and poor discharge practice. Actions as a result of safeguarding incidents were implemented and monitored. The trust annual report included reference to learning and the implementation of new guidance and policies. More staff needed to complete training as only 72% of staff had completed training.
- The trust Safeguarding Children Leads Forum is responsible for the implementation of and monitoring compliance with the Safeguarding Children Policy. The trust safeguarding lead was the Chief Nurse and there was a named doctor and named nurse. Divisional managers and line managers had a key responsibility to ensure procedures were followed.

Summary of findings

- The trust was working with partners to ensure an area wide approach to child protection. The annual report demonstrated a multi-agency approach to safeguarding issues and learning from serious case reviews. Child protection procedures were followed and there had been an increasing number of alerts demonstrating increasing recognition and action regarding vulnerable children and young people. Actions as a result of safeguarding incidents were implemented and monitored although further audit was recommended. The trust annual report included reference to learning from national enquiries. More staff needed to complete training as only 72% of designated staff working in or around children had completed Level 1, 73% level 2, and 71% level 3.

Incidents

- Staff told us how they were encouraged to report incidents, near misses and errors and that they received feedback and learning was shared within clinical teams. There was evidence that learning was shared across the trust, but this varied in some service areas.
- The trust had reported 6,544 incidents to the NRLS from February 2014 to January 2015. This was below the England average but similar to expected rate of NRLS incidents. The majority (94%) of these incidents were low risk or no harm incidents. Moderate incident accounted for 5% of all incidents and serious incidents (severe harm or death) 1%.
- The trust Serious Event Review Group monitored incidents, instigated investigation and produced guidance and learning. The group monitored changes took place following incidents. The majority of serious incidents had been for pressure ulcers (grade 3 and 4) and slips, trips and falls. We found that incidents had been investigated through root cause analysis and the learning implemented. The trust had not reported a Never Event in 2013 to 2014. Never Events are serious, largely preventable patient safety incidents, which should not occur if the available preventative measures have been implemented. However, the process to classify never events was not clear and there was one serious incident which fell into the category that was not classified as a never event because there was no harm to the patient. The classification is based on the type of incident rather than harm.
- We reviewed three Serious Incidents and found these to be well structured, with appropriate conclusions and recommendations with specific responsibilities and timescale for actions identified. There were prompts to share wider learning across the trust.

Summary of findings

Staffing

- The divisions reported monthly on nurse staffing numbers. Staffing numbers were identified based on the acuity tool used by the trust. Shifts were agreed in advance against the planned registered nurse to patient ratios required for each shift and these were rated Red Amber or Green (RAG) in terms of staff numbers. Any shifts that could not be adequately staffed on the rota were escalated and reported on. The majority of shifts were staffed as planned (higher than minimum staffing levels) or were lower than planned but above minimum staffing levels. There were no red shifts where the nurse staffing level was deemed unsafe. This had been the pattern from January to June 2015. Staffing levels were monitored at division and board level and staffing levels were published appropriately. There were escalation procedures and contingency plans to maintain actual staffing levels.
- The hospital had a significant number of vacancies particularly in emergency medicine, medical and older people's care, surgery and children's and young people's services. The trust was no longer using agency staff, unless this was absolutely necessary, and action was taken to fill vacancies from bank staff.
- However, some medical and surgical wards did not always meet safe staffing levels. Nursing staff were coping by working longer hours, sharing staff or staff skills across shifts. For some nurses the workload was high and the unpredictability as to which ward they might be working on was a concern and could not be sustainable. Some escalation procedures were identified as lengthy in some areas. Overall, patients on these wards told us their needs were being met. However, we found in some areas, staffing levels did have an impact and patient needs were not always met.
- The trust was implementing actions to mitigate staffing concerns for example, by developing skills in health care assistants. There was also innovation in developing new roles for staff, for example, majors practitioners in the emergency department and advanced critical care practitioners. The trust had an ongoing recruitment campaign and had recruited a significant number of nurses from overseas (the Philippines) to fill vacancies and had expected staff to start in September 2015. However, the trust was affected by government immigration rules and nursing was currently not deemed to be a profession that was in short supply. The overseas recruitment process had currently been halted.

Summary of findings

- Medical staffing levels across the hospital were appropriate. National recommendations were followed, for example, for consultant presence in the emergency department, maternity, critical care and end of life care. There was consultant presence in the hospital over seven days with the exception of surgical services, although there were 24 hour consultant cover arrangements across all services. Consultants in children and young people services were working additional sessions because of vacancies with junior doctors at middle grade level. This additional working was not sustainable in the long term.
- The average midwifery staff ratio was 1:30, although this could be higher at times. This was below the England average of 1:29 and the recommendations of the Royal College of Obstetricians and Gynaecologists' guidance (Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour, October 2007) that there should be an average midwife to birth ratio of 1:28. Midwives, however, were working flexibly and longer hours at times, and one to one care was being provided for women in labour.
- Radiographers at Royal Hampshire County Hospital worked alone overnight covering imaging services for the hospital and the emergency department. Radiographers reported a heavy workload and raised concerns about manual handling issues. Between 10.00pm and 8am, radiology was supported by an overnight outsourced radiologist service. Staff identified delays in the process to authorise request and provide advice on imaging which meant delays in the patient diagnosis.

Are services at this trust effective?

By effective, we mean that people's care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence.

Overall we rated the effectiveness of the services at the trust as 'good'. For specific information, please refer to the individual reports for Andover War Memorial Hospital, Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital.

Evidence-based care and treatment

- Staff were providing care and treatment to patients that took account of national and best practice guidelines. For example, from NICE and relevant Royal Colleges to guide care and

Good



Summary of findings

treatment in local pathways, care bundles and procedures. In most areas there was adherence to guidance and policies, although in the MIU there were no clinical guidelines or pathways in use.

- In some areas, guidelines had been unified across the trust for consistency of care.
- Each clinical service area had an audit programme. Audits in most areas were prioritised based on national audits, or local issues. Completion of audits varied but this was monitored and there was evidence of action taken following recommendations. There was, however, less evidence of re-audit and improvement as part of the audit cycle.
- The trust reviewed NICE guidance to agree its use and to monitor implementation across services.
- The trust clinical quality and safety committee had agreed new terms of reference in May 2015. The committee had a much clearer role in setting and monitoring performance and standards.

Patient outcomes

- Services were monitoring the standards of care and treatment. Most patient outcomes were similar to or better than the England average. There were action plans to address where outcomes were worse when compared to the England average.
- Mortality rates in the trust were within expected range. The trust monitored mortality within clinical teams where there were regular monthly mortality and morbidity meetings, some of which happened with staff from across the trust hospital sites. The trust had reviewed its mortality rates at points of high risks. For example, when the trust had experienced a high number of emergency admissions and overcrowding last winter and at the weekends where mortality rates had increased slightly but remained in expected range. The hospital did not identify any increase in avoidable deaths.
- Patients who had suffered a stroke would be taken to the Royal Hampshire County Hospital as this was the designated receiving unit for the specialist treatment of stroke in Hampshire. For October 2014 to December 2014, the hospital performed better than other trusts for meeting standards for specialist assessments, thrombolysis and provision of physiotherapy and occupational therapy and discharge processes. The hospital was similar to other trusts for care on the stroke unit, multi-disciplinary working and standards of discharge standards. The hospital performed significantly worse than other trusts in providing speech and language therapy and scanning.

Summary of findings

- Patients with chest pain were taken to Basingstoke and North Hampshire Hospital as the designated centre for specialist treatment if possible. The hospital's performance was better than national average for patients with non-ST segment elevation myocardial infarction (a type of heart attack) who were seen by a cardiologist or a member of their team and treated on a cardiac ward or unit. The hospital performed below the national average for patients being referred for or had angiography.

Multidisciplinary working

- Staff were supported to access training. Many staff had a high level of competency having undertaken specialty specific qualifications. There was evidence of regular staff appraisal although clinical supervision varied.
- Staff worked effectively in multidisciplinary teams to centre care around patients. This included working with GPs, community services, other hospitals. For example, in reach services with mental health teams and with community and social care to support complex discharges. There were innovations in electronic records and the use of video conferencing in end of life care that enabled information to be shared about patient's clinical needs and preferences across the trust, and with community and GP services. However, paediatric inpatient physiotherapy was not sufficient for children and young people with Cystic Fibrosis at the weekends and this was concern.
- GP discharge summaries were timely to support seamless care, although there were delays (which had improved during the inspection) in paediatric services in BNHH.
- Seven day services were developed in particularly for emergency care. However, therapy, diagnostic and pharmacy services were under-developed to support seven day working.

Consent, Mental Capacity Act & Deprivation of Liberty safeguards

- Staff had appropriate knowledge of the Mental Capacity Act 2005 and Deprivation of Liberty Safeguards to ensure that patients' best interests were protected. Guidance was available for staff to follow on the action they should take if they considered that a person lacked mental capacity. Notification of Deprivation of Liberty Safeguards applications were correctly submitted to the Commission. However, the capacity assessments were not always documented or regularly reviewed in patient care records.

Summary of findings

- ‘Do Not Attempt Cardio Pulmonary Resuscitation’ (DNACPR) forms were not always appropriately completed and did not include, for example, an assessment of the patient’s mental capacity. Trust wide audit was demonstrating that completion was improving and we observed during inspection that the majority of forms were appropriately completed.

Are services at this trust caring?

By caring, we mean that staff involve and treat patients with compassion, kindness, dignity and respect.

Overall we rated the caring provided by staff at the trust as ‘outstanding’. For specific information, please refer to the individual reports for Andover War Memorial Hospital, Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital.

Patients, their families and carers told us staff were ‘excellent, kind and helpful’ and many ward areas could demonstrate the compliments and thank you cards they had received. The trust had a culture of compassionate care. Staff were highly motivated to provide compassion care that promoted people’s dignity. Many services had a strong visible person-centred approach with individual patient preferences and needs reflected in how care was delivered.

Compassionate care

- The trust values ‘CARE’: Compassion, Accountability, Respect, and Encouragement were demonstrated and embraced by the staff from across the trust.
- Staff were caring and compassionate, and treated patients with dignity and respect. There was a culture in the hospital of understanding and responding to patient’s individual needs. This covered clinical and non-clinical staff such as porters and housekeeping staff who recognised the importance of their role in providing good quality care. Staff were focused on providing individual, person centred care to patients and their families.
- Patient feedback was overwhelming positive across all services. Prior to our inspection, patients and the public had contacted us to praise the trusts services. During our inspection, many patients and relatives told us that although staff were very busy in places, they were supported with compassion and patience, and were treated with dignity and respect.
- We observed staff introducing themselves to patients by their preferred name and responding to call bells promptly. Staff in

Outstanding



Summary of findings

the outpatient departments were approachable, reassuring and professional and supported patients with any aspect of care to reduce their anxiety, for example, renewing a patient's car parking ticket.

- We observed outstanding care and compassion in critical care, children and young people's services, end of life care and outpatient services. Staff were person-centred and supportive, and worked to ensure that patients and their relatives were actively involved in their care. They had developed trusting relationships with patients and their families.
- Data from the national surveys demonstrated that the hospital was similar to other trusts. Patients were very satisfied and would recommend the care they received.
- Staff maintained patient's confidentiality, privacy and dignity in all areas, although the layout of bay areas in a few areas may have compromised patient's dignity at times.

Understanding and involvement of patients and those close to them

- Patients and their relatives felt involved in their care and treatment, staff provided information and explanations in a way patients could understand. Patients felt that their views and considerations were listened to and acted upon. They told us their care and treatment options had been explained to them at all times and they had sufficient opportunity to speak with consultant staff.
- Patients, their relatives or carers were involved in their care and in some places, active partners, with staff empowering patients to have a voice in their care. Patient's emotional and social needs were highly valued by staff and were embedded in their care and treatment.
- In many clinical areas we saw how staff supported patients and their families to understand their care and be involved. For example, in critical care, records of conversations were detailed on patient records. This meant staff always knew what explanations had been provided and this reduced the risk of confusing or conflicting information being given to relatives and patients. In children and young people's services, play leaders spent time with children to support them to understand their care and the environment was adapted (ie a LEGO MRI model) so children could understand their care.
- The families of patients receiving end of life care told us they were informed about the condition of their relative and had time to speak with doctors and they did not feel rushed. They told us that staff were good at communicating and had, for example, discussed death or dying in a comforting manner.

Summary of findings

Relatives told us they were encouraged to get involved in the care of patients. Patients at the end of their life were identified with a butterfly symbol so that all staff could be aware and sensitive to their needs and the needs of their family and friends.

Emotional support

- Staff across the trust demonstrated a good understanding of patient's and relatives emotional needs
- Patients and their families were supported by staff emotionally to reduce anxiety and concern. There was also support for carers, family and friends for example, from the chaplaincy, bereavement services for patients having end of life care, and counselling support where required.
- Psychological support was also available. For example, stroke patients had a mood assessment pathway and had appropriate clinical psychological referral. Psychology services were available for children and young people living with long-term conditions and receiving specialist services and surgical amputee patients. Clinical nurse specialists offered support for specific conditions.
- We saw many examples of staff instinctively offering emotional support. For example, in the emergency department, staff gave open and honest answers to questions and provided as much reassurance as possible. In outpatient services, staff instinctively recognised when patients required extra support and spent time with patients to reduce their anxiety and distress, and support their treatment plans.
- We also saw examples where services were being tailored to provide further emotional support. For example, patients with complex needs on care of elderly wards discharged to a new home were escorted by a member of nursing or therapy staff who spent up to an hour with patients in their new home. Patients and their families were supported through end of life care. Between six and eight weeks following a patient's death a bereavement card, signed by the trust chief executive, would be sent to the patient's family. Bereavement evenings were held three times a year on each of the three hospital sites and a counsellor from the specialist palliative care team would be in attendance. Where additional bereavement support was required contact numbers for external bereavement counselling services would be offered

Summary of findings

Are services at this trust responsive?

By responsive, we mean that services are organised so that they meet people's needs.

Overall we rated the responsiveness of services at the trust as 'good'. For specific information, please refer to the individual reports for Andover War Memorial Hospital, Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital.

Good



Service planning and delivery to meet the needs of local people

- The trust understood the needs of its local population and was planning service change in response to the increasing demand for services. The most urgent problem, that of increasing number of emergency admissions and patient flow through the hospital, was being managed. Escalation and contingency plans had two main overriding objectives¹. For safe, high quality services to patients including effective management of infection, ensuring patients are seen at the right place and right time; and maintaining privacy and dignity.². Achievement of key areas of service, including Emergency department access, ambulance turnaround times, and urgent and other elective operations and including elective cardiology. The lessons learnt included the need to plan for higher acuity patients, additional capacity and community wide response and escalation.
- The trust had analysed the socio-economic profile and demographics of its geographical surrounding areas. The challenge of an ageing population with multiple co-morbidities was representing a significant and increasing (reflected nationally) emergency admissions problem. The current configuration of trust services across three hospital sites also presented clinical and workforce sustainability challenges. The trust had strategic plans to centralise emergency and urgent care service in a new critical treatment hospital, and with partners integrating care across health and social care particularly for children, elderly, those with long term conditions and those requiring mental health services.
- Some operational changes had occurred to centralise services, for example, BNHH is the designated receiving hospital for cardiac patients and RHCH the designated receiving unit for stroke patients. Consultants led services across the trust in emergency medicine and critical care. However, some services were reaching their sustainability threshold in terms of quality and safety, for example, children and young people's services. The trust was continuing to plan for clinical areas to have closer

Summary of findings

working arrangements to ensure strategic, operational and clinical benefits were realised. However, these plans were centred on the new hospital rather than formal plans to progress ongoing working arrangements.

- Services were being planned to respond to increases in demand, staff capacity and patient needs. There was some innovation in models of care, for example, ambulatory care, acute assessment unit and early supported discharge. Children's and young people services had reduced the number of beds to respond to staffing issues. There was also joint work with partners, for example, to in-reach services for psychiatric assessment and integrated discharge to support patients with complex needs. There was however, not a clear model of short and medium term planning across services.
- The trust offered a number of one stop clinics. The breast unit, for example, offers appointments to patients within two weeks following GP referral. The referrals were initially received into the central booking office and prioritised by consultants. Patients who attended the one stop clinics would see a clinician, have a biopsy taken and see a radiologist if required. If a cancer diagnosis was suspected, patients were told before leaving the clinic and an appointment given to discuss the outcome and treatment options. This unit provided a responsive service for patients who were anxious in relation to a potential cancer diagnosis.
- The trust had commissioned an external management consultancy to review the capacity and productivity of services where waiting list targets were not being met and/or there were concerns with management processes. These were in outpatients, orthopaedics and ophthalmology services, to improve the discharge of frail elderly patients, improving staff engagement in streamlining emergency care and improving the speed at which TTO (to take out) drugs were delivered on discharge.
- The hospitals environment required refurbishment in a few areas and some areas would eventually require redesign in response to changes in demand for services.

Meeting people's individual needs

- Support for people with a learning disability needed further development. Although there was support for carers, the hospital needed a flagging system or passport to identify and support patients, and some staff identified the need for further training.

Summary of findings

- There were arrangements with the local NHS mental health trust to provide a liaison service for people with a learning disability and mental health disorders. The mental health team worked in the emergency department and inpatient areas. The trust had a mental health specialist midwife and a consultant trained in perinatal mental health problems.
- There were arrangements for the trust to work with social care and the local community trust to support the discharge of patients with complex needs.
- Patients having end of life care were identified by a Butterfly symbol so that staff were aware of their needs and those of their family.
- All wards we visited provided care for patients in single sex accommodation bays, in line with Department of Health requirements. However, the layout of bay areas in the AAU at BNHH and Victoria Ward at RHCH may have compromised patient's dignity at times.
- An interpreting service was available for people whose first language was not English although some staff were not aware of how to access this. All information for patients was only available in English and we did not see any information in an easy-to-read format.

Access and flow

- Bed occupancy in the trust was below the England average of 88%, although this was higher on surgical wards. It is generally accepted that at 85% level, bed occupancy can start to affect the quality of care provided to patients, and the orderly running of the hospital.
- The trust was not meeting the national emergency access target for 95% of patients to be admitted, transferred or discharged within 4 hours. Ambulance handovers over 30 minutes were often delayed and patients often had to wait in the emergency department for admissions.
- During our inspection, there were very few medical patients on outlier wards (a ward that is not specialised in their care). Information from the trusts demonstrated that these patients were regularly assessed.
- Patient bed moves happened frequently, including at night. Staff were ensuring that patients with lower dependency needs were moved and patients had not expressed concern about their moves.

Summary of findings

- The trust was achieving the 31-day cancer waiting time diagnosis-to-treatment target and the 62-day referral-to-treatment target, although this had not been met in June 2015.
- The trust was achieving the 18-week referral-to-treatment time target for medical patients and some surgical patients. The target was not being achieved in orthopaedics and ophthalmology.
- The majority of patient who had cancelled surgical procedures for non-clinical reasons were rebooked for surgery within 28 days.
- The trust was meeting national waiting times for diagnostic imaging within six week, outpatient appointments within 18 weeks and cancer waiting times for urgent referral appointments within 2 weeks and diagnosis at one month and treatment within two months.
- The trust cancellation rate for appointments was 10%; the England average was 7%. Many of these clinic cancellations were at short notice. The reasons for this varied and included cancellation for staff sickness, training and annual leave. There was a plan to address this but this was in development. Patients were not appropriately monitored to ensure the timeliness of re-appointments
- Women were able to make choices about where they would like to deliver their babies. They had access early pregnancy assessment and their preferred ante-natal clinics. Women in the early stages of labour had access to telephone support.
- Patient discharge was effectively supported. Patients were regularly reviewed and discharge coordinators worked to improve the discharge of patients with complex care needs. There was a discharge lounge for medical patients and early supportive discharge for stroke patients. The trust had problems with increasing numbers of delayed transfers of care for community services, and was working with partners to improve this.
- There was a hospital at home service to deliver care to those patients identified as being in the last days or hours of life. The service was 24 hours and seven days a week. Multidisciplinary team working and innovations in electronic records and the use of video conferencing in end of life care also facilitated rapid assessment and access to equipment.
- Patients having end of life care had multi-disciplinary care focused on their physical, mental, emotional and social needs. Patients could have a rapid discharge to home arranged within 24 hours. However, there were delays to the rapid and fast track discharge processes (within 48 hours) and processes were being improved to meet national standards.

Summary of findings

- All wards we visited provided care for patients in single sex accommodation bays, in line with Department of Health requirements.

Dementia

- The trust demonstrated good practice in dementia care. There was formal leadership, management and monitoring arrangements for the implementation of the trust strategy.
- The trust dementia strategy 2014-15 promoted the key aspect of the national dementia strategy of raising awareness and understanding, early diagnosis and support, and living well dementia. The national CQUIN outcome had financial incentives by the clinical commissioning group for achieving progress in the following key areas
 - To find, assess, investigate and refer - The proportion of patients aged 75 and over to whom case finding is applied following emergency admission, the proportion of those identified as potentially having dementia who are appropriately assessed, and the number referred on to specialist services.
 - Clinical Leadership - Named lead clinician for dementia, dementia strategy, “This is me” promotion and appropriate training for staff.
 - Supporting carers - Supporting carers of people with dementia, including the provision of written information.
- The trust had improved its performance against the national CQUIN dementia targets. The trust exceeded the target for 90% of patients over 75 years to be asked dementia case finding questions, and for patients to have a diagnostic assessment and be referred for further diagnostic advice. However, referrals for further advice were not consistently on target. (April 2014 – March 2015). The targets had been met from June 2014.
- The trust had a dementia steering group to oversee and monitor the implementation of the strategy. Progress against the CQUIN and action plan was monitored monthly. There was a dementia nurse specialist and two clinical lead nurses and a consultant lead for dementia.
- All patients over 75 years were screened for dementia using a recognised methodology on their admission. The patients living with dementia were assessed by the dementia specialist nurse who visited all the care of elderly wards and also saw referrals on the other medical wards. Staff had completed basic dementia awareness training. The wards we visited had a named dementia champion. The trust had developed a ‘dementia care bundle’ which assisted staff to meet the needs of these patients.

Summary of findings

- The trust had introduced the 'this is me' booklet for patients living with dementia, which had been developed by the Alzheimer's Society to alert and inform staff to identify and meet the needs of these patients. On the care of elderly wards we saw that patients living with dementia had the booklet and it was appropriately completed. Between January to March 2015, the booklet was used for 52% of eligible patients.
- A 'sunflower' symbol was used to identify people living with dementia on wards. The sunflower was displayed above their beds to raise awareness of dementia and highlight additional communication needs. Between January to March 2015, the symbol was used for 69% of eligible patients.
- The dementia action plan included the 'red rule' that no patient with dementia is moved (except from the ED, AAU or emergency treatment) to another ward area after 8pm. Breaches were being monitored and had decreased.
- The trust had surveyed carers and had responded to feedback on the need for further support. Some of the wards we visited displayed information that they were taking part in "John's campaign". This is a national campaign promoting the right for carers to stay with people with dementia when they are in hospital. Carers were encouraged to stay on the ward outside the normal visiting hours, they had organised meals for carers who help feed their relatives at meal times and free parking for carers who come into help with the personal care for their relatives. There was a focus on improved communication with patients and carers to ensure they feel supported at discharge; this included working with our partner organisations to ensure follow ups in the community happen in a timely way.
- All carer's had been provided with an information leaflet and had received a postcard and information from the specialist dementia team following the assessment of patients.
- Patients had access to a dementia link nurse from the medical wards. Staff had good awareness and training and there were dementia champions on the wards we visited. The hospital had also trained a number of volunteers specifically to support of care of people living with dementia and they spent time talking to patients on the ward.

Learning from complaints and concerns

- Complaints were handled appropriately and there was evidence of improvements to services as a result.

Summary of findings

- Divisions were responsible for handling complaints. The trust had a complaints and patient experience team who supported divisions ensuring consistent approaches with the trust complaints policy. There were weekly and monthly reports to the division and an annual report to the trust board.
- During 2013/14 the trust handled a total of 606 complaints. This was a similar number when compared to the previous year. The most common themes were similar to the NHS and were clinical treatment (including delayed diagnosis), communication, staff attitude and delays or cancellations (waiting times and appointments). There was evidence of learning and improvements to services as result of complaints, for example, introducing a medicines helpline for patients following discharge, a carer's survey, patient information and training for staff.
- Throughout 2013/14 an average of 94% of complaints were acknowledged within the Department of Health three working days expected timeframe. An average of 54% of all complaints responded to within the trust target of 25 working days. The average response time was 53 days. The trust was taking action to improve its responsiveness to complaints. All complaints had included an apology and were signed by the CEO.
- We reviewed three recent complaints. These complaints were responded to according to guidelines and there were adequate details and clarity on the lessons learnt.
- During 2013/14 the Parliamentary and Health Service Ombudsman (PHSO) had 9 complaint contacts from the trust. Five cases were still open. Of the remaining four, two were not accepted for investigation, one was not upheld and one was partially upheld. The main recommendation was for the trust to improve its falls management procedures and policies and the trust had taken action on this, including the appointment of a falls coordinator, dementia nurse specialist and risk assessment process.
- The trust had plans to improve staff training in handling complainants, improve the level of local resolution, improve the grading of severity and escalation of complaints within divisions, improve monitoring and ensure action is taken on lessons learnt, and survey patients who had made a complaint about the process.
- Overall patients were aware of how to complaint or raise concerns; information was available but not in all areas of the trust. Staff followed trust policy to resolve concerns. There was a patient support services team to support patients to raise concerns and issues informally. The majority of concerns were being resolved within 48 hours.

Summary of findings

Are services at this trust well-led?

By well led, we mean that the leadership, management and governance of the organisation assure the delivery of high quality person-centred care, supports learning and innovation, and promotes an open and fair culture.

Overall we rated the leadership of the trust as 'good'. For specific information, please refer to the individual reports for Andover War Memorial Hospital, Royal Hampshire County Hospital and Basingstoke and North Hampshire Hospital.

The trust had a five year strategy that aimed to deliver high quality safe patient care through transforming services. There was a focus on emergency care to build a new critical treatment hospital and deliver local care in the general hospitals and integrated health and social care closer to home. There were operational plans to focus on priorities and immediacy of capacity issues. However, clinical services did not have strategic plans to develop in the short and medium term.

Governance arrangements were well developed at trust, division, clinical service and ward level. The trust had a comprehensive integrated performance report to benchmark quality, operational and financial information. Clinical quality dashboards were available from board to ward to improve the quality of information, monitoring and reporting. Risks were appropriately managed and escalated to the board, although this varied in some areas.

The trust had benefitted from the duration of the working relationships amongst its leadership team. Whilst challenge and reflective scrutiny had continued, the maturity of the organisation was such that there could be an unconscious way of working where structures were sometimes less significant. The leadership team had recognised the need for succession planning and an external assessment of its governance arrangements. The trust needed to improve its use of internal audit and clinical audit to review governance arrangements and provide assurance around risks and effectiveness.

The leadership team showed commitment, enthusiasm and passion to develop and continuously improve services. The trust could demonstrate improvement against many of its quality priorities, although the level of avoidable harms, such as falls and pressure ulcers, remained the same.

Staff at every level told us about the visibility and support of the chief executive. Staff were positive about working for the trust and

Good



Summary of findings

the quality of care they provided. Many felt engaged with the trust priorities although some were concerned that they were not being listened to, and there was low morale in places based on staffing issues and management decisions.

The culture of the organisation was different across the three sites. The merger or harmonisation of hospitals (the trust preferred term) was acknowledged as work in progress but was seen as successful overall. There was a difference in confidence with the staff at Andover War Memorial Hospital, Royal Hampshire County Hospital (RHCH), Winchester and Basingstoke and North Hampshire Hospital (BNHH). There had also been variable progress with integrated working across the three sites. The trust was sighted on priority areas where patient safety, clinical effectiveness and operational risks might occur.

There was a focus on improving patient experience and public engagement to develop services. The public were involved in nominating staff that demonstrated excellent practice through the WOW! Award scheme.

The trust supported and encouraged staff to innovate and improve services.

Cost improvement programmes were identified with clinical staff and were assessed for risks and monitored. Savings and productivity, however, were not being delivered as planned mainly because of the cost of emergency admissions and the trust was in a managed financial deficit.

The trust was in discussion with commissioners about plans for the critical treatment hospital. Whilst the clinical model was understood there was concern about its affordability and sustainability. There was ongoing discussion and debate about the viability of different options and the risks involved. A decision had yet to be made.

Vision and strategy

- The trust strategic plan 2014/19, was a five year forward plan based on the delivery of safer, more sustainable services and better outcomes for patients. The vision was to provide a new model of service delivery in the form of a new critical treatment hospital. The proposal is based on national and local strategies and recommendations to deliver high quality seven day services, centralised specialist care and services that are local and care closer to people's homes.
- The hospital strategy aimed to provide emergency care for the sickest patients (about 15% of patients) through the centralisation of emergency care, critical care, out of hours

Summary of findings

theatres and inpatient children's care. This would include, for example, services for heart attacks, acute strokes, trauma, emergency surgery, critical care, very sick children and obstetric care. It was proposed that this would provide more efficient services through the elimination of duplicate high costs, facilities and equipment, and would support the retention of staff. The existing hospitals would provide non-emergency general hospital services. This would include, for example, urgent care, rapid medical assessment, outpatient and diagnostic services, care of the elderly and rehabilitation services, maternity centre services, elective surgery for 85% of patients. The trust would work with partners to deliver care close to home, for example, using fixed and mobile services to deliver walk-in urgent care, outpatient consultation, diagnostic services and some planned medical and surgical interventions. Some services also reach into patients' homes, for example maternity and community children's services.

- The trust currently worked across three hospital sites at BNHH, RHCH and Andover War Memorial Hospital. The new critical treatment hospital build was planned midway between Winchester and Basingstoke. There was commitment to this plan and the trust had bought the option on the land, employed architects and the construction company. However, the proposals had yet to be formally agreed and relied on the agreement of partners, commissioners and Monitor, the health regulator.
- The new hospital model was the single strategic focus in terms of the future development of the trust and the trust had not proposed alternative strategies. Any alternative to develop services on the existing estate was seen as equally high risk as services would need to change and facilities resigned in the current hospitals to provide specialist centralised care and use resources effectively. All clinical services identified their new critical treatment hospital model as their overall strategy and there were in-depth plans towards this across services. Services, however, did not have development plans in the short and medium term.
- The trust operational plan 2014/16 focused on priority issues around demand, capacity, workforce, and organisational development. There were short term resilience projects around quality priorities (eg reducing pressure ulcers and improving the management of sepsis) and operational requirements (eg improving the four hour waiting time the emergency department and waiting lists for surgery)

Summary of findings

- Staff were aware of the trust strategy as the long term future plan. Some consultants identified concerns with the plans for the new hospital.

Governance, risk management and quality measurement

- The trust strategy 2014 -19 included its quality priorities around patient safety, clinical effectiveness and patient experience indicators. The trust quality governance structure was part of its operational performance and delivery structure. This was managed by divisions that reported to the trust executive committee which reported to the trust board. There were other groups to manage specific areas of governance, such as medicines management, safeguarding, or serious incidents. Clinical services within divisions held monthly governance meetings to review quality, risks and operational performance. Services had effective clinical governance arrangements to monitor quality, risk and performance. The outpatients department needed to further improve processes to manage risk and quality.
- The divisions provided monthly reports on quality, performance and delivery and quality dashboards were available at division, clinical services and wards level. The trust had an integrated performance report which the board reviewed monthly. This included data on performance, quality, finance and the workforce collated at a trust wide level. The trust could demonstrate improvement against many of its quality priorities, although the level of avoidable harms, such as falls and pressure ulcers, remained the same.
- All divisions and their clinical services had risk registers. These identified key risks and mitigating actions and controls were detailed. High risks issues were escalated to the trust risk register, although this varied. High (red rated) risks in surgery, for example, were not on the trust risk register.
- The corporate risk register included clinical, organisational and financial risks, and used likelihood and impact/severity criteria for risks to develop a ratings score. The board assurance framework was monitored monthly. This was used to identify the top strategic and operation risks and there was a predictive tool to identify and provide assurance on actual, anticipated, and potential risks. The board had undertaken a risk appetite assessment which identified their tolerance or exposure to specific strategic risks.
- The current trust governance framework was devised at the point of the merger. The framework did not have a board committee that focused directly on clinical quality and safety. There was a clinical quality and safety committee (CQSC),

Summary of findings

chaired by the chief medical officer, reporting to the trust executive committee. The CQSC committee did not meet monthly, and in the recent past, several months had elapsed between meetings. The committee was described as a space to allow for considerations of a more conceptual and strategic nature, which was valued. It was not clear how the board received the necessary systematic and regular assurances about clinical quality processes. The Committee had updated its terms of reference in May 2015 to focus on the assurance and performance element of quality and safety.

- The trust had benefitted from the duration of the working relationships amongst its leadership team. This had been a strength and we did not find any evidence that the familiarity of relationships had led to a lack of routine challenge and reflective scrutiny. We did find that the maturity of the organisation was such that there could be an unconscious way of working where structures were sometimes less significant. Part of the purpose of the governance framework is to provide stability and continuity during periods of organisational change, challenge, stress and/or personnel change; and to ensure that there is systematic challenge and scrutiny. There were areas of governance that needed to improve. For example, the trust had not used internal audit or clinical audit to review governance arrangements or provide detailed assurance around risks. The clinical audit programme had not been evaluated or monitored to determine if programmes were aligned to risks and if actions were implemented following audit to improve clinical effectiveness. An audit planned for 14/15 to examine the implementation of recommendations flowing from serious incidents was not conducted nor commenced. The trust had not yet undertaken an independent external assessment of the governance framework since merger and this was recognised by the leadership team.

Leadership of the trust

- The trust had a stable trust board leadership team. The chief executive officer (CEO) had been in post for approximately 12 years, the chief medical officer 11 years and the chief nurse/ chief operating officer for 15 years, the chief finance officer for five years. A director of transformation was a recent appointment and had started in the trust in July 2015. The Chair and Non-executive directors had also been in post for a number of years.
- The non-executive directors (NED) had a broad range of business and commercial experience. The trust had made a

Summary of findings

deliberate choice on the skills of the NEDs to complement the clinical leaders that already existed in the trust. The NEDs provided insight, challenge, and new perspectives to the range of trust decisions. The NEDs were a strong, effective and cohesive group. They demonstrated an understanding of the trust strategic and operation risks and a commitment to the safety and quality agenda. As a group they were definitive about the high level of challenge they were required to make and response they would always expect from the trust. Rather than specific roles, the NEDs were required to have the range of responsibility and understanding across the agenda of the trust board. There was an understanding of collective responsibility and support for board activities.

- The trust had an active and well-structured council of governors whose remit was to advise on the trust's strategic direction, gather views on trust services for the local community, approve board appointments and accounts, and participate in programmes agreed by the board. The governors held regular listening events in community areas, and were involved in governor's visits across the trust sites to report on patient experience. They were members of various trust groups to support improvements in care and services. The board and governors worked well together.
- The leadership team showed commitment, enthusiasm and passion to develop safe, quality services for patients. They were rising to the challenge of continuous quality improvement alongside a rising demand for services and financial constraints.
- The board had undertaken a self-evaluation in May 2015. This identified that the board had a good blend of skills and experience and worked in an open, transparent, constructive and collaborative way. The leadership of the chairman promoted effective decision making and constructive debate and the board approach to risk was to question and learn rather than apportion blame. The board needed the time spent reviewing strategy and succession planning. The training of directors, particularly NED specific training, needed to be reviewed. There were learning points identified on the need for HR skills at board level, improved communication with the CCGs, how the board are made aware of organisational changes and reducing the detail in trust board papers identifies, and more board involvement in the trust annual report.
- The leadership team were clear about the strategic direction of the trust, and this resonated through the organisation. The focus was on a clinically-led organisation and there was

Summary of findings

devolved leadership model to divisions with consultants engaged in the running of the trust with managers. There was a medical director and operational director lead for each division and clinical directors in each clinical service areas. The aim was for consultant and practitioner led clinical services and clinical leaders were being developed through leadership programmes. Many staff told us overall they had good support from the local clinical leaders and staff engagement was good.

- The NHS Staff Survey 2013 identified that the trust was similar to other trusts for the percentage of staff reporting good communication between senior management and staff. Staff were overwhelmingly positive about the visibility and approachable leadership style and support of the CEO.
- Staff were aware of the reasons for change within the organisation but there were a few areas of tension between senior consultants and the rationale and clinical models planned within the proposed critical care treatment hospital. Some staff felt they had not been appropriately consulted on trust plans. Some staff also identified tensions working through layers of operational management and inequalities in pay and support for administrative and clerical staff.
- The trust had managed the merger in 2012 by creating a mergers and acquisition committee as a sub-committee of board. This had provided the leadership team with the time and space to plan the integration of services and build the culture needed across the trust. The committee had specific goals and the trust described the merger as “half way through the change journey” having made good progress.

Culture within the trust

- The values of the trust were defined in CARE: Compassion, caring about our patients and each other. Accountability and responsibility to improve. Respect for all colleagues, patients and their families. Encouraging and challenging each other to always do our best. All staff in all areas were aware of the values of the trust and many staff verbalised, and demonstrated, their passion and the committed to ensuring the quality of the service they provide. There was a strong focus on patient centred care. There was an openness and transparency about when things go wrong and staff were supported to report incidents.
- It had been three years since the trust merger in January 2012 and there was a sense, across all hospital sites, of pre- and post-merger identities. For the most part, however, the majority of staff understood the necessity for the merger and the

Summary of findings

benefits that had occurred. The merger or harmonisation of hospitals (the trust preferred term) is acknowledged as work in progress but is seen as successful overall. The RHCH had gained financial investment, and improved quality and safety procedures. The BNNH had experienced a negative impact with a drop in performance (now being regained) but had increased its sense of leadership and innovation. The merger was still described as work in progress but many staff reported that the change had been managed well. There remained some issues with management layers and changes, a sense that BNHH was the preferred location to pilot innovations and staff at the Andover War Memorial Hospital felt a 'disconnect' from the wider trust. There was a difference in culture and confidence across the three hospital sites with staff at BNHH feeling more empowered to make decisions.

- In devising the future strategy the trust had been clear that services needed to work together to improve clinical, workforce and financial stability. The trust was actively supporting integration across sites. Nurse leaders worked across all hospital sites. There were teams where medical staff worked well together and across sites, for example, in emergency medicine, critical care, stroke and cardiac services, pathology services and palliative care. There were areas, however, where medical staff were not integrated and in some areas did not work well together. For example, in paediatrics, radiology, surgery, maternity, and acute general medicine. This would become a critical concern for some services where the failure of integration was exposing patient safety and non-clinical risks, for example, lack of specialisation, agreed guidelines and problems maintaining appropriate staffing levels. The trust is sighted on priority areas.

Fit and Proper Persons Requirement

- The trust was prepared to meet the Fit and Proper Persons Requirement (FPPR) (Regulation 5 of the Health and Social Care Act (Regulated Activities) Regulations 2014) to ensure that directors of NHS providers are fit and proper to carry out this important role.
- The trust had agreed its Fit and Proper Persons Policy in May 2015. The policy was thorough in its approach to relevant checks and due diligence in the appointment of new directors, ongoing compliance of existing director and monitoring of compliance. However, this had only recently been agreed. There was no evidence of audit or current monitoring.

Summary of findings

Public engagement

- The trust had a patient experience plan to demonstrate improvements in complaints handling and learning from complaints; improvements in patient experience through the Friends and Family Test; to act on patient feedback and to implement change; to development support for carers and making patients more involved in decisions, for example through better patient information. There was a focus on support for patients living with dementia.
- Patient engagement was mainly through survey feedback however, there was innovation to improve engagement in clinical areas. For example the use of social media in maternity, afternoon tea sessions with stroke patients and their families, and evening events for bereavement families.
- Patient listening sessions “Through your eyes” had started in the surgical division in July 2014. Patient who had complained are invited to clinical areas to share experiences directly with a small group of staff. The learning and improvement from this initiative has led to this being adopted trust wide. The sessions were planned bi-monthly.
- The trust had trained 500 volunteers to support patients and people visiting the trust. Some volunteers had specific roles. Dementia volunteers offered companionship and social activities, there was a befriending service for cancer patients and mealtime volunteers who had been specifically trained by dietitians and speech and language therapists.
- The trust hosts an annual Director of Nursing Awards (DONA) ceremony for staff. This award publicly celebrates nurses and midwives, and nursing and midwifery teams. Nominations are made by members of the public for an individual or a team for their care, commitment and compassion. Last year, there were 214 nominations from members of the public for staff to receive a DONA award
- There were examples of public engagement work, for example the trust newsletter, social media and the “Ask Mary” direct contact email to the Chief Executive. There was partnership working with the Alzheimer’s Society for dementia care and with the local Healthwatch to improve access for the growing Nepalese community in Hampshire.
- The trust internet included information on plans for the new critical treatment hospital. Patients and the public were aware of the trusts strategic vision and plans. There were plans for public consultation on the proposals.

Staff engagement

Summary of findings

- The trust was similar to other trusts for in the NHS staff survey 2014. The trust only had two negative indicators (the bottom 20% of trusts). These were percentage of staff working extra hours and the percentage of staff reporting errors, near misses or incidents witnessed in the last month. However, the percentage agreeing that they would feel secure raising concerns about unsafe clinical practice was significantly better than other trusts.
- Staff were positive about working for the trust and were proud of the quality of patient care they provided. They also identified and valued the visibility and approachability and support provided by the chief executive officer.
- Many staff were positive about the trust's strategic priorities and identified the opportunities where they had been consulted and engaged. For example, workshops had been held on plans for the new hospital. However, some staff felt their concerns were not heard and this had worsened since the merger and the enlargement of trust. Some consultant staff identified that they had not been sufficiently involved in plans for the new hospital and 'agreed' clinical model. They identified concerns and gaps in thinking about the clinical pathway for patients.
- Clinical staff, in many areas, were working longer hours to sustain services. Non-clinical support staff, such as administrative staff, cleaners and porters, also indicated they were working long hours. Staffing concerns were identified as the main issue that might cause low staff morale. In some areas where staff had left the trust, the financial position of the trust had meant their roles had not been replaced and were being absorbed by other staff. Some administrative staff felt their contribution was not valued and there was concern expressed by the administration review which had led to dissatisfaction and low morale as staff working in different divisions were considered to be graded differently for similar roles. Staff also expressed some frustration with layers of management processes for operational and escalation issues.
- The trust had developed the ZEST programme for staff to support their health and wellbeing. The programme provided advice and support on healthy eating, physical exercise and work life balance.
- Information from previous staff survey had identified issues with bullying and harassment. The trust had developed a toolkit in 2014 (called 'A spotlight on bullying and harassment: A Toolkit to work with bullying and harassment'). The toolkit

Summary of findings

was acknowledged by the RCN as a model of good practice. The trust NHS staff survey had demonstrated a decline in the percentage of staff experience harassment, bullying or abuse in 2014 when compared with 2013.

- The trust presented a monthly WOW! Award recognising when staff go the extra mile. During 2014/15 there have been a total of 1166 WOW! Award nominations which were made by staff and the public for individuals and teams across the Trust. Nominations were made in the category of 'Above and Beyond', customer care, patient safety and innovation. Nominations are considered by a panel which includes Foundation Trust governors and a small number of winners are chosen who are surprised in their workplace by Chief Nurse Donna Green and presented with a certificate. WOW! Award winners are invited to a quarterly celebration lunch with their colleagues, the board of directors and Foundation Trust governors. Recognition through the WOW Awards had led to high levels of staff satisfaction throughout the service.
- An initiative called Front line Friday allowed non-clinical staff experience to care for patients. Non-clinical staff spent a day or half a day to help with clinical practice on the wards. Many staff had participated including a NED of the trust.

Innovation, improvement and sustainability

- Staff were being encouraged to innovate and improve services through the trust Action 4 Quality programme, clinical audit programmes and research projects (130 clinical trials were underway that improved patient choice). There was a focus to encourage these programmes to have a direct impact on services. Although this varied, the trust could demonstrate improvements to services based on staff innovation.
- During the year 2015/16, the trust position was a proposed deficit of £2m. The leadership also supported the development of stretch financial targets to enable the loan for the new Critical Treatment Centre to be delivered. Cost improvement programmes (CIPs) focused on cost savings, better procurement and increasing productivity through workforce changes, sharing resources (for example, across sites) and increasing capacity (for example, additional clinics or theatre sessions). There had been a high degree of clinical consultation to develop the CIPs, for examples, clinicians had trialled new devices for procurement prior to high volume contracts. CIPs were clinically led within divisions and risks to quality and safety assessed. All CIPs were rated in terms of risk.

Summary of findings

- Financial pressures were exacerbated by emergency admissions and staffing costs. In 2014/15, the trust had achieved 58% of its cost improvement delivery plan which represented savings of £6.8m compared to the Plan of £11.6m (58%). The main shortfall was in the medical division representing the impact of operational pressures (emergency admissions) during the year.
- As a trust, the use of agency staff had been stopped with some limited exceptions for high risk situations in emergency care.
- The trust was generating income through the development of private practice at the Candover Unit. There were financial incentives in contracts generated through commissioning for quality and innovation (CQUINS) priorities for the trust. These included dementia and delirium outcomes, improving response rate to the Friends & Family Test and patient experience metrics. The trust was demonstrating improvements in these areas.
- The trust's performance was reviewed by the health regulator, Monitor. The continuity of service rating was 2. The rating is based on the risk the trust could fail to carry on as a going concern, A rating of 1 indicates the most serious risk and 4 the least risk. A rating of 2 means the trust financial position is unlikely to get worse. The trust had a governance risk rating of green (no evidence of concern in how the service is run). Monitor is requesting further information following a continuity of service risk rating of 2 and deterioration in the trust's forecast financial position, before deciding next steps.
- The trust was in discussion with its commissioners and Monitor about the proposed critical treatment hospital. Whilst the clinical model was understood there was concern about the affordability and sustainability of this capital project. There was alignment with the commissioner's strategic model on the principles for the redesign of local hospital services to meet demands; to integrate care across health and social care particularly for children, elderly, those with long term conditions and those requiring mental health services; and ensure long term financial stability across the health economy. Commissioners also had a focus to develop primary and community services to provide more care closer to home and reduce demand for emergency admissions. The premise that the centralisation of resources would outweigh the additional costs of the new service model and provide long term sustainability was under discussion. The viability of different options and the risks involved meant a decision had yet to be made.

Overview of ratings

Our ratings for Andover War Memorial Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Requires improvement	Requires improvement	Good	Good	Requires improvement	Requires improvement
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Good	Requires improvement	Good	Requires improvement	Requires improvement	Requires improvement
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
End of life care	Good	Good	Outstanding	Good	Outstanding	Outstanding
Outpatients and diagnostic imaging	Good	Not rated	Good	Good	Requires improvement	Good
Overall	Good	Requires improvement	Good	Good	Requires improvement	Requires improvement

Overview of ratings

Our ratings for Basingstoke and North Hampshire Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Requires improvement	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	 Outstanding	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	 Outstanding	Good	Good	Good
End of life care	Good	Good	 Outstanding	 Outstanding	 Outstanding	 Outstanding
Outpatients and diagnostic imaging	Good	Not rated	 Outstanding	Good	Good	Good
Overall	Requires improvement	Good	 Outstanding	Good	Good	Good

Overview of ratings

Our ratings for Royal Hampshire County Hospital

	Safe	Effective	Caring	Responsive	Well-led	Overall
Urgent and emergency services	Good	Good	Good	Requires improvement	Good	Good
Medical care	Good	Good	Good	Good	Good	Good
Surgery	Requires improvement	Good	Good	Good	Good	Good
Critical care	Good	Good	Outstanding	Good	Good	Good
Maternity and gynaecology	Good	Good	Good	Good	Good	Good
Services for children and young people	Good	Good	Outstanding	Good	Good	Good
End of life care	Good	Good	Outstanding	Good	Outstanding	Outstanding
Outpatients and diagnostic imaging	Requires improvement	Not rated	Outstanding	Good	Requires improvement	Requires improvement
Overall	Requires improvement	Good	Outstanding	Good	Good	Good

Our ratings for Hampshire Hospitals NHS Foundation Trust

	Safe	Effective	Caring	Responsive	Well-led	Overall
Overall	Requires improvement	Good	Outstanding	Good	Good	Good

Notes

Outstanding practice and areas for improvement

Outstanding practice

- The trust is one of only two designated specialist treatment centres in the country for treatment of Pseudomyxoma. This is a very rare type of cancer that usually begins in the appendix, or in other parts of the bowel, the ovary or bladder. The hospital has treated more than 1000 such cases. The diverse multidisciplinary team has developed the skills to help patients through this extensive treatment, and share their knowledge on international courses and conferences.
- Through audit surgeons working at the trust have changed practice world-wide, such as new techniques for the biopsy on operable tumours and the benefits of waiting six weeks after completing chemotherapy before performing liver resection.
- GPs had access to electronic information held by the trust. This meant they were able to access electronic discharge summaries with up to date information available about care and treatment patients had received in hospital.
- LEGO brick Model, designed by a play leader, was used to prepare children for MRI scans. The model was successful in reducing children's fears and apprehension. The model had been adopted for use in other hospital.
- The trust was developing innovative new roles for staff, for example, major practitioners in the emergency department and advanced critical care practitioners.
- Every medical and care of elderly ward had an activity coordinator who planned and conducted different activities for patients after consulting them. The activities included range of things such as arts and craft, music, dance, group lunches and movie time.
- Afternoon tea session was held for patients and their relatives in the stroke wards. This gave patients an opportunity to share their experiences, peer support and education. The session was also attended by a member of stroke association team who delivered educational sessions related to care after stroke. Patients were also given information about support available in the community.
- A nurse led eight bedded day unit in the admissions and discharge lounge for patients who required certain medical interventions. Patients were referred to this service by the medical consultants and this service was helping to meet needs of patients who required medical intervention without prolonging their stay in the hospital. Patients were highly complimentary about this service.
- When patients with complex needs on care of elderly wards were discharged to their new home, they were escorted by a member of nursing or therapy staff to who spent up to an hour with patients in their new home. This had helped in offering elderly patients with emotional support.
- The early supported discharge team helped stroke patients for up to six weeks following their discharge from the hospital. The staff felt that this gave continuity of care and supported the patients in achieving their goals following the discharge
- Once a week the librarian attended the ward round in order to source relevant literature to assist the professional development of staff.
- Critical care career pathways were developed to promote the development of the nursing team.
- The critical care unit had Innovative grab sheets that detailed the essential equipment to care for each patient in the event the unit had to be evacuated. These included pictures of the essential equipment, so non-clinical staff such as portering staff could help collect the equipment ensuring medical and nursing care of patients was not interrupted.
- The breast care unit is a fully integrated multi-disciplinary unit that was pioneering intraoperative radiotherapy for breast cancer at the Royal Hampshire County Hospital.
- Kingfisher ward had activity coordinators who planned and conducted different activities for patients after consulting them. There was a range of activities offered, including arts and crafts, music, dance, group lunches and movie time.
- Pregnant women were able to call Labour Line which was the first of its kind introduced in the country. This service involves midwives being based at the local ambulance operations centre. Women who called 999 could discuss their birth plan, make arrangements for their birth and ongoing care. The labour line midwives

Outstanding practice and areas for improvement

had information about the availability of midwives at each location and were able to discuss options with women and their partners. Labour Line midwives were able to prioritise ambulances to women in labour if they were considered an emergency. The continuity of care and the rapid discharge of ambulances when they are really needed, have been two of the main benefits to women in labour. The Labour line had recently won the Royal College of Midwives Excellence in Maternity Care award for 2015 and they were also awarded second place in the Midwifery Service of the Year Award.

- The specialist palliative care team provided a comprehensive training programme for all staff involved in delivering end of life care.
- The cardiac palliative care clinic identified and supported those patients with a non-cancer diagnosis who had been recognised as requiring end of life care.
- The use of the butterfly initiative in end of life care promoted dignity and respect for the deceased and their relatives.
- There was strong clinical leadership for the end of life service with an obvious commitment to improving and sustaining care delivery for those patients at the end of their lives.
- All staff throughout the hospital were dedicated to providing compassionate end of life care.
- The Countess of Brecknock Hospice contacted bereaved relatives following the death of a relative and, sent a card on the anniversary of the patient's death.
- The hospice at home service was proactive in supporting patients in their own home.
- All staff throughout the Countess of Brecknock Hospice were dedicated to providing compassionate end of life care.

Areas for improvement

Action the trust MUST take to improve

Action the trust MUST take to improve

The trust must ensure:

- Patients in the ED are admitted, transferred or discharged within national target times of four hours.
- There is an appropriate system to identifying patients with a learning disability.
- Nurse staffing levels comply with safer staffing levels guidance.
- The emergency resuscitation trolleys are appropriately checked and are sealed or tagged.
- Medicines are appropriately managed and stored in surgery
- Controlled drugs in liquid form are managed and stored appropriately in all the medical wards.
- The early warning score is used consistently in surgery and a system is developed for use in outpatients.
- Venous thromboembolism assessment occurs on admission for surgical patients
- Resuscitation equipment is appropriately checked and items are sealed and tagged.
- Staffing in radiology complies with guidance so that staff do not have heavy workloads and manual handling risks and staff have access to appropriate advice.
- There is effective partnership working so that children and young people with mental health needs (CAMHS) have timely assessment and care reviews.
- Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.
- The outsourced diagnostic imaging service is appropriately monitored and managed to reduce delays.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up
- MIU staff have access to up to date approved Patient Group Directions (PGDs)
- MIU staff receive update mandatory training in basic life support and infection control
- staff said
- Safeguarding checks are consistently completed and recorded
- There is a clear hospital protocol for responding to a collapsed patient in an emergency at Andover War Memorial Hospital
- There is appropriate security on site for the protection of staff and patients in the MIU at Andover War Memorial Hospital

Outstanding practice and areas for improvement

- Leadership concerns in the MIU are addressed and there is effective leadership from the nurse clinical lead and lead consultant to monitor and maintain clinical standards.
- There is an effective system to identify, assess, monitor and improve the quality and safety of the MIU, the day care unit and outpatient services.

The trust should

- Develop clinical service strategies that support planning, cross site working and the sustainability of services.
- Continue plans for the harmonization of services across hospital sites to ensure consistency of service, staff confidence and opportunity for innovation across hospital sites.
- Ensure governance arrangements are formally evaluated and action is taken around areas of risk and effectiveness.
- Implement recommendations as planned from the board evaluation report including implementation of HR representation on the board and improving external relationships
- Ensure all staff feel appropriate engaged with plans for the new critical treatment hospital and clinical models are agreed.

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Surgical procedures Treatment of disease, disorder or injury	<p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2010 Cleanliness and infection control</p> <p>Regulation 12 HSCA 2008 (Regulated Activities) Regulations 2014: Safe Care and Treatment</p> <p>Regulation 12 (1) (2) (a), (b), (c), (e), (g),</p> <p>How the regulation was not being met:</p> <p>The trust must ensure:</p> <ul style="list-style-type: none">• Medicines are appropriately managed and stored in surgery.• Controlled drugs in liquid form are managed and stored appropriately in all the medical wards.• Resuscitation equipment is appropriately checked and items are sealed and tagged.• The early warning score is used consistently in surgery.• Venous thromboembolism assessment occurs on admission for surgical patients.• Staffing in radiology comply with guidance so that staff do not have heavy workloads and manual handling risks and staff have access to appropriate advice.• The outsourced diagnostic imaging service is appropriately monitored and managed to reduce delays.• There is effective partnership working so that children and young people with mental health needs (CAMHS) have timely assessment and care reviews.• Children with cystic fibrosis are supported by appropriate paediatric physiotherapy.

Requirement notices

- MIU staff have access to up to date approved Patient Group Directions (PGDs).
- MIU staff receive update mandatory training in basic life support and infection control.
- Safeguarding checks are consistently completed and recorded in the MIU
-

Regulated activity

Treatment of disease, disorder or injury

Regulation

Regulation 17 HSCA (RA) Regulations 2014 Good governance

Regulation 17 HSCA 2008 (Regulated Activities) Regulations 2014: Good governance

Regulation 17 (1), (2) (a), (b).

How the regulation was not being met:

The trust must ensure:

- Patients in the ED are admitted, transferred or discharged within national target times of four hours.
- There is an appropriate system to identify patients with a learning disability.
- There is a clear hospital protocol for responding to a collapsed patient in an emergency
- There is appropriate security on site for the protection of staff and patients in the MIU.
- Leadership concerns in the MIU are addressed and there is effective leadership from the nurse clinical lead and lead consultant to monitor and maintain clinical standards.
- There are appropriate processes and monitoring arrangements to reduce the number of cancelled outpatient appointments and ensure patients have timely and appropriate follow up.

This section is primarily information for the provider

Requirement notices

- There is an effective system to identify, assess, monitor and improve the quality and safety of the MIU, the day care unit and outpatient services

Regulated activity

Surgical procedures
Treatment of disease, disorder or injury

Regulation

Regulation 18 HSCA (RA) Regulations 2014 Staffing

**Regulation 18 HSCA 2008 (Regulated Activities)
Regulations 2014: Staffing**

Regulation 18 (1)

How the regulation was not being met:

The trust must ensure:

- Nurse staffing levels comply with safer staffing levels guidance at Basingstoke and North Hampshire Hospital .